MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE

Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 is to be completed by the authorized Health Care Provider.
FOR SEIZURE/CONVULSION/EPILEPSY MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

Place Child's Picture Here (Optional

CHILD'S NAME: _____ Date of Birth: ____/_____/_____ Date of Plan: _____

Significant Medical/Health History: _____

Seizure Triggers or Warning Signs: _____

Allergies: _____

Seizure Care Information

Seizure Type	Length (duration)	Frequency	Description

Seizure Emergency Protocol: How to respond to a seizure (Check all that apply)

❒ First Aid – Stay. Safe. Side (refer to resource document "Seizure First Aid Guide")
❒ Call 911 for transport to _____ ❒ Notify parent or emergency contact
❒ Notify Health Care Provider _____ ❒Other _____
❒ Administer emergency medications as indicated below:

Medication Name & Strength	Dosage	Route/Method	Time & Frequency	Special Instructions

Care after seizure: Does the child need to leave the classroom after a seizure? ❒ **Yes** ❒ **No**

What type of help is needed? (describe) _____

When can the child return to care/resume regular activity? _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

_____

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (original signature or signature stamp only) DATE (mm/dd/yyyy)		

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE

Seizure/Convulsion/Epilepsy Disorder
Medication Administration Authorization Form

Child's Name:_____ Date of Birth:_____

PARENT/GUARDIAN AUTHORIZATION		
I authorize the child care staff to administer the medication as prescribed above. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.		
PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:	1. Medication named above was received. Expiration Date _____	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Staff has received additional training to administer the medication	☐ Yes ☐ No ☐N/A
	If Yes: Trainer Name and Title_____	Date_____
	6. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No
	7. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐N/A
	8. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐N/A

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REASON MEDICATION WAS GIVEN	SIGNATURE